Complete Summary

GUIDELINE TITLE

Stress related conditions and other mental disorders.

BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Stress related conditions and other mental disorders. Corpus Christi (TX): Work Loss Data Institute; 2007 Apr 12. 153 p. [204 references]

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.
- October 17, 2005, Cymbalta (duloxetine hydrochloride) : Healthcare professionals notified of revision to the PRECAUTIONS/Hepatotoxicity section of the prescribing information to include precaution against using in patients with chronic liver disease.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **
SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Work-related stress and other mental disorders

GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

To offer evidence-based step-by-step decision protocols for the assessment and treatment of workers' compensation conditions

TARGET POPULATION

Workers with occupational stress and other mental disorders

INTERVENTIONS AND PRACTICES CONSIDERED

The following interventions were considered and recommended as indicated in the original guideline document:

1. Acceptance and commitment therapy (ACT)
2. Activity restrictions/Work modifications

3. Antidepressants (the choice of first-line therapy between selective serotonin reuptake inhibitors [SSRIs] and tricyclic antidepressants [TCA] is currently under study)
4. Aromatherapy
5. Cognitive therapy for depression, panic disorder, post-traumatic stress disorder, and general stress
6. Cognitive behavioral stress management (CBSM)
7. Computer-assisted cognitive therapy
8. Depression screening
9. Disease management programs
10. Distractive methods
11. Duloxetine (Cymbalta®)
12. Electroconvulsive therapy (ECT)
13. Exercise
14. Expatriate employee adjustment support
15. Kava extract (for anxiety)
16. Light therapy
17. Massage therapy
18. Mind/body interventions (relaxation)
19. Minnesota multiphasic personality inventory (MMPI)
20. Music (for relaxation/stress management)
21. Opioid antagonists (naltrexone, acamprosate) for alcohol dependence
22. Patient education (to reduce stress-related illness)
23. Peer support (for postpartum depression)
24. Psychological evaluations
25. Return to work
26. St. John's wort
27. Stress inoculation training
28. Stress management, behavioral/cognitive interventions
29. Stress management, physical interventions (aerobic exercise)
30. Therapist optimism
31. Yoga

The following interventions/procedures are under study and are not specifically recommended:

1. Acupressure
2. Acupuncture
3. Antidepressants - SSRIs versus TCAs
4. Brain wave synchronizers for stress reduction
5. Depression: effect on heart health and the gene factor
6. Eye movement desensitization and reprocessing (EMDR)
7. Folate (for depressive disorders)
8. Hypnosis
9. Pharmaceuticals versus behavioral therapy for tension headaches
10. Psychosocial and pharmacological treatment (for deliberate self harm)
11. SAMe (S-adenosylmethionine)
12. Stress and effects: atherosclerosis, blood pressure, depression, heart-related interventions, mental performance, and physiology
13. Vitamin and mineral supplements including vitamins B6 and B12

The following interventions/procedures were considered, but are not recommended:

Psychological debriefing (for preventing post-traumatic stress disorder)

MAJOR OUTCOMES CONSIDERED

Effectiveness of treatments in reducing stress and anxiety

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Work Loss Data Institute (WLDI) conducted a comprehensive medical literature review (now ongoing) with preference given to high quality systematic reviews, meta-analyses, and clinical trials published since 1993, plus existing nationally recognized treatment guidelines from the leading specialty societies. WLDI primarily searched MEDLINE and the Cochrane Library. In addition, WLDI also reviewed other relevant treatment guidelines, including those in the National Guideline Clearinghouse, as well as state guidelines and proprietary guidelines maintained in the WLDI guideline library. These guidelines were also used to suggest references or search terms that may otherwise have been missed. In addition, WLDI also searched other databases, including MD Consult, eMedicine, CINAHL, and conference proceedings in occupational health (i.e. American College of Occupational and Environmental medicine [ACOEM]) and disability evaluation (i.e. American Academy of Disability Evaluating Physicians [AADEP], American Board of Independent Medical Examiners [ABIME]). Search terms and questions were diagnosis, treatment, symptom, sign, and/or body-part driven, generated based on new or previously indexed existing evidence, treatment parameters and experience.

In searching the medical literature, answers to the following questions were sought: (1) If the diagnostic criteria for a given condition have changed since 1993, what are the new diagnostic criteria? (2) What occupational exposures or activities are associated causally with the condition? (3) What are the most effective methods and approaches for the early identification and diagnosis of the condition? (4) What historical information, clinical examination findings or ancillary test results (such as laboratory or x-ray studies) are of value in determining whether a condition was caused by the patient's employment? (5) What are the most effective methods and approaches for treating the condition? (6) What are the specific indications, if any, for surgery as a means of treating the condition? (7) What are the relative benefits and harms of the various surgical and non-surgical interventions that may be used to treat the condition? (8) What is the relationship, if any, between a patient's age, gender, socioeconomic status and/or racial or ethnic grouping and specific treatment outcomes for the condition? (9) What instruments or techniques, if any, accurately assess

functional limitations in an individual with the condition? (10) What is the natural history of the disorder? (11) Prior to treatment, what are the typical functional limitations for an individual with the condition? (12) Following treatment, what are the typical functional limitations for an individual with the condition? (13) Following treatment, what are the most cost-effective methods for preventing the recurrence of signs or symptoms of the condition, and how does this vary depending upon patient-specific matters such as underlying health problems?

Criteria for Selecting the Evidence

Preference was given to evidence that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reports a cohort study, whether prospective or retrospective, or (5) The article reports a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

More information about the selection of evidence is available in "Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument" (see "Availability of Companion Documents" field).

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Ranking by Type of Evidence

1. Systematic Review/Meta-Analysis
2. Controlled Trial-Randomized (RCT) or Controlled
3. Cohort Study-Prospective or Retrospective
4. Case Control Series
5. Unstructured Review
6. Nationally Recognized Treatment Guideline (from www.guideline.gov)
7. State Treatment Guideline
8. Other Treatment Guideline
9. Textbook
10. Conference Proceedings/Presentation Slides

Ranking by Quality within Type of Evidence

a. High Quality

b. Medium Quality
c. Low Quality

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Work Loss Data Institute (WLDI) reviewed each article that was relevant to answering the question at issue, with priority given to those that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reported a cohort study, whether prospective or retrospective, or (5) The article reported a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

Especially when articles on a specific topic that met the above criteria were limited in number and quality, WLDI also reviewed other articles that did not meet the above criteria, but all evidence was ranked alphanumerically (see the Rating Scheme of the Strength of Evidence field) so that the quality of evidence could be clearly determined when making decisions about what to recommend in the Guidelines. Articles with a Ranking by Type of Evidence of Case Reports and Case Series were not used in the evidence base for the Guidelines. These articles were not included because of their low quality (i.e., they tend to be anecdotal descriptions of what happened with no attempt to control for variables that might effect outcome). Not all the evidence provided by WLDI was eventually listed in the bibliography of the published Guidelines. Only the higher quality references were listed. The criteria for inclusion was a final ranking of 1a to 4b (the original inclusion criteria suggested the methodology subgroup), or if the Ranking by Type of Evidence was 5 to 10, the quality ranking should be an "a."

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Prior to publication, select organizations and individuals making up a cross-section of medical specialties and typical end-users externally reviewed the guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary. The recommendations that follow are based on the previous version of the guideline.

Initial Diagnosis

Stress is the most common mental condition treated by occupational or primary care physicians and will be the focus of this guideline. References to additional mental disorders are found in the procedure summary in the original guideline document, although the more severe of those usually require referral to a specialist. Stress is not its own diagnosis but rather a combination of nonspecific emotional or physical symptoms varying in intensity and duration, which may or may not be related to a specific incident. The stress might also be associated with a particular disease or syndrome, but that is not always the case.

A stressor is defined as anything that exerts a physical, emotional, or mental demand on an individual. Stress often occurs when the individual has anxiety because of a mismatch between perceived demands and resources, whether work-related or personal. The source of stress can be acute (such as an employee relocation) or chronic (such as consistently poor relations with a supervisor).

For some people, stress causes or contributes to a deterioration of physical health, resulting in more headaches or more common colds. While the scientific literature is not clear on this topic, stress may also contribute to the worsening of more serious conditions such as heart disease, irritable bowel disease, or ulcers, depending on the individual's coping methods. On the other hand, the presence of certain physical conditions could be the cause of stress.

Initial Evaluation

Focus on identifying possible red flags or warning signs for potentially serious psychopathology that would require immediate specialty referral. Red flags may include impairment of mental functions, overwhelming symptoms, signs of substance abuse, or debilitating depression. In the absence of red flags, the occupational or primary care physician can handle most common stress-related conditions safely.

In talking to the patient, it is important for the physician to get him or her to try and explain or pinpoint incidents or reasons for the stress, rather than to just generalize (i.e., "I hate my job," "Everything makes me stressed out," etc.). The physician may have to ask more specific questions about work or home life if the patient is initially unwilling or unable to address specific issues.

Occupational stress usually stems from one of three common models:

1. *Person-environment fit model*: Poor job fit, such as a mismatch between the skills of the individual and the demands of the job, or a disparity between the individual's career-related desires versus actual opportunities presented, is a leading cause of workplace stress.
2. *Demand control model*: Jobs that place high demands on the worker but give him or her little control or opportunities for decision-making lead to high job strain, a source of stress that is consistently linked as a contributor to physical conditions such as cardiovascular mortality, heart disease, and hypertension. Consideration should be given to the influence of the individual's occupational and personal history, which may have an effect on how this model applies to his or her situation.
3. *Effort-reward model*: Shows that stress is often the result of high effort without social reward. Like the demand control model, this model points out that a low ratio of effort to reward leads to sustained autonomic arousal and can cause physical effects such as high blood pressure or myocardial infarction.

Exploration of how and if the patient's stress follows the path of one of the above models will be helpful in determining treatment.

More specific sources of stress include bereavement, illness, familial changes or disorder, or other common and/or traumatic life changes. Time off work may be helpful, although the ultimate goal should be to preserve the patient's ability to function both occupationally and socially. Time off should not be so excessive that the employee loses his or her sense of function and appreciation at work and at home.

Initial Therapy

1. Pursuing the patient's thoughts on how his or her stress relates to the above models may help determine the source of stress and cultivate ideas on how to eliminate or cope with the stress. Patient education and understanding about stress is necessary for effective stress management to take place.
2. Other common treatment pathways include the use of one or more of the following:
    a. Relaxation techniques (such as meditation)
    b. Exercise (aerobic exercise has been shown to positively influence mood)
    c. Behavioral training (such as time management, anger management, assertiveness, or conflict resolution training)
    d. Stress inoculation therapy
    e. Cognitive therapy
    f. Modified work
    g. Organizational interventions

3. Pharmaceutical therapy (limited, short-term use of anti-anxiety agents to improve function--anything else should be used in conjunction with a specialty referral)

Follow-up visits are an important part of treatment and should be conducted by a mid-level practitioner in person or via phone every three or four days, depending on the severity of the case, while a path to recognizable treatment is established and followed. Failure to improve or make significant progress after several months may indicate the need for psychiatric assessment or counseling.

Official Disability Guidelines (ODG) Return-To-Work Pathways

Senile and Presenile Organic Psychotic Conditions (see original guideline document for International Classification of Diseases, Ninth Revision [ICD-9] codes for this and other diagnoses)

Not severe, medical treatment: 0 days

Severe, specially designed, limited modified work: 7 days

Severe, regular work: indefinite

Senile Dementia with Delusional or Depressive Features

Severe, specially designed, limited modified work: 7 days

Severe, affecting fellow worker productivity & safety: indefinite

Severe, regular work: indefinite

Alcohol Withdrawal Delirium

Without hospitalization: 1 to 7 days

Including rehab, substance abuse professional (SAP) evaluation: 28 days

Including rehab, SAP evaluation, job safety issues: 42 days

Drug Withdrawal Syndrome

Without hospitalization: 0 to 5 days

With hospitalization, without suicidal ideation: 7 days

With hospitalization, with suicidal ideation: 21 days

Paranoid and/or Hallucinatory States Induced by Drugs

Without hospitalization: 1 to 3 days

With hospitalization, without threat of harm: 7 days

With hospitalization, with threat of harm: 21 days

Transient Organic Psychotic Conditions

14 days

Paranoid Type

Without hospitalization, no job safety issues: 0 to 7 days

With hospitalization: 42 days or by report

Unspecified Schizophrenia

Without hospitalization, no job safety issues: 0 to 7 days

With hospitalization: 16 to 42 days

Major Depressive Disorder, Single Episode

Rule out impaired mood/personality disorder: 0 days

Outpatient therapy, without symptoms affecting work: 0 to 7 days

Outpatient therapy, with symptoms interfering with work: 21 to 42 days

With hospitalization, non-cognitive/modified work: 21 days

With hospitalization, cognitive work: 42 days

Major Depressive Disorder, Recurrent Episode

Outpatient therapy, without symptoms affecting work: 0 to 7 days

Outpatient therapy, with symptoms interfering with work: 14 to 28 days

With hospitalization, non-cognitive/modified work: 21 days

With hospitalization, cognitive work: 42 days

Bipolar Affective Disorder, Depressed

Rule out impaired mood/personality disorder: 0 days

Without hospitalization: 0 to 21 days

With hospitalization: 21 to 42 days

Bipolar Affective Disorder, Mixed

Without hospitalization: 0 to 14 days

With hospitalization: 21 to 42 days

Paranoia

Without hospitalization: 0 to 14 days

With hospitalization: 14 to 21 days

Depressive Type Psychosis

Without hospitalization: 0 to 56 days

With hospitalization: 21 to 64 days

Anxiety States

Rule out impaired mood/personality disorder: 0 days

Without hospitalization: 0 to 7 days

With hospitalization: 14 to 21 days

Panic Disorder

1 to 14 days

Generalized Anxiety Disorder

14 to 21 days

Hysteria

Without hospitalization: 0 days

With hospitalization: 7 to 14 days

Obsessive-Compulsive Disorders

Without hospitalization: 0 days

With hospitalization: 10 days

Personality Disorders

0 days

Alcohol Dependence Syndrome

Without hospitalization: 1 day

Without hospitalization, considering fellow worker danger & morale: 7 to 14 days

With hospitalization, including rehab: 14 to 28 days

Safety sensitive position: as determined by the SAP

Acute Alcoholic Intoxication

1 to 2 days

Also treated as rule violation absence

Opioid Type Dependence

Without hospitalization: 0 days

Without hospitalization, considering fellow worker danger & morale: 7 to 14 days

With hospitalization, including rehab: 14 to 38 days (10 days post-discharge)

Safety sensitive position: as determined by the SAP

Barbiturate and Similarly Acting Sedative or Hypnotic Dependence

Without hospitalization: 0 days

Without hospitalization, considering fellow worker danger & morale: 7 to 14 days

With hospitalization: 21 days

With hospitalization, plus rehab: 28 days

Safety sensitive position: as determined by the SAP

Cocaine Dependence

Without hospitalization: 0 days

Without hospitalization, considering fellow worker danger & morale: 7 to 14 days

With hospitalization: 28 days

Safety sensitive position: as determined by the SAP

Cannabis Dependence

0 to 2 days

Amphetamine and Other Psychostimulant Dependence

Without hospitalization: 0 days

Without hospitalization, considering fellow worker danger & morale: 7 to 14 days

With hospitalization: 14 days

With hospitalization, plus rehab: 28 days

Safety sensitive position: as determined by the SAP

Hallucinogen Dependence

Without hospitalization: 0 days

Without hospitalization, considering fellow worker danger & morale: 7 to 14 days

With hospitalization: 10 days

With hospitalization, plus rehab: 28 days

Safety sensitive position: as determined by the SAP

Alcohol Abuse

1 day

Cocaine Abuse

Without hospitalization: 0 to 1 days

With hospitalization: 10 days

With hospitalization, plus rehab: 28 days

Amphetamine or Related Acting Sympathomimetic Abuse

Without hospitalization: 1 day

With hospitalization: 14 days

With hospitalization, plus rehab: 28 days

Acute Reaction to Stress

Without hospitalization (on-going counseling/drug therapy): 1 day

With hospitalization: 10 days

Unspecified Acute Reaction to Stress, Post-traumatic Stress Disorder

Without hospitalization (on-going counseling): 1 day

With hospitalization: 10 days

Chemical dependence comorbidity: 28 days

Adjustment Reaction

Without hospitalization: 1 to 6 days

Outpatient care: 1 to 6 days

With inpatient hospitalization: 14 to 28 days

Postconcussion Syndrome

Mild: 1 day

Severe: by report

Depressive Disorder, not Elsewhere Classified

Rule out impaired mood/personality disorder: 0 days

Outpatient therapy, without symptoms affecting work or other job issues: 0 to 7 days

Outpatient therapy, with symptoms interfering with work: 21 days

Outpatient therapy, with serious job satisfaction issues: 28 to 42 days

With hospitalization, non-cognitive/modified work: 28 days

With hospitalization, cognitive work: 42 to 56 days

Attention Deficit Disorder

1 day

(See *ODG Capabilities & Activity Modifications for Restricted Work* under "Work" in the Procedure Summary of the original guideline document)

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

During the comprehensive medical literature review, preference was given to high quality systematic reviews, meta-analyses, and clinical trials over the past ten years, plus existing nationally recognized treatment guidelines from the leading specialty societies.

The heart of each Work Loss Data Institute guideline is the Procedure Summary (see the original guideline document), which provides a concise synopsis of effectiveness, if any, of each treatment method based on existing medical evidence. Each summary and subsequent recommendation is hyper-linked into the studies on which they are based, in abstract form, which have been ranked, highlighted and indexed.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

These guidelines unite evidence-based protocols for medical treatment with normative expectations for disability duration. They also bridge the interests of the many professional groups involved in diagnosing and treating work-related stress and other mental disorders.

POTENTIAL HARMS

- From a clinical point of view the analysis of antidepressants' safety profile (adverse effect and suicide risk) remains of crucial importance and more reliable data about these outcomes are needed.
- First-generation selective serotonin reuptake inhibitors (SSRIs) often produce multiple side effects that many patients find intolerable, and the risk for harm when taken in overdose or in combination with certain medications is high.
- The risk of suicidal behavior after starting antidepressant treatment is similar among users of amitriptyline (a tricyclic) and fluoxetine (an SSRI).
- Despite the relative low prevalence of side effects associated with SSRIs a significant minority of older people find these drugs intolerable and experience nausea, vomiting, dizziness and drowsiness.
- Postmarketing reports of hepatic injury (including hepatitis and cholestatic jaundice) suggest that patients with preexisting liver disease who take duloxetine may have an increased risk for further liver damage. The new labeling extends the Precaution against using Cymbalta in patients with substantial alcohol use to include those patients with chronic liver disease. It is recommended that Cymbalta not be administered to patients with any hepatic insufficiency.

- Hypomania as a potential adverse effect of light therapy needs to be considered.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Patient Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 (revised 2007 Apr 12)

GUIDELINE DEVELOPER(S)

Work Loss Data Institute - Public For Profit Organization

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Editor-in-Chief, Philip L. Denniston, Jr. and Senior Medical Editor, Charles W. Kennedy, MD, together pilot the group of approximately 80 members. See the ODG *Treatment in Workers Comp* Editorial Advisory Board.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

There are no conflicts of interest among the guideline development members.

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

GUIDELINE AVAILABILITY

Electronic copies of the updated guideline: Available to subscribers from the Work Loss Data Institute Web site.

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Background information on the development of the Official Disability Guidelines of the Work Loss Data Institute is available from the Work Loss Data Institute Web site.
- Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument. Available to subscribers from the Work Loss Data Institute Web site.

PATIENT RESOURCES

The following is available:

- Appendix B. ODG Treatment in Workers' Comp. Patient information resources. 2006.

Electronic copies: Available to subscribers from the Work Loss Data Institute Web site.

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on April 4, 2005. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on October 20, 2005, following the U.S. Food and Drug Administration advisory on Cymbalta (duloxetine hydrochloride). This NGC summary was updated by ECRI on January 30, 2006, November 13, 2006, April 2, 2007, and August 29, 2007. This summary was updated by ECRI Institute on October 31, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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Date Modified: 9/22/2008